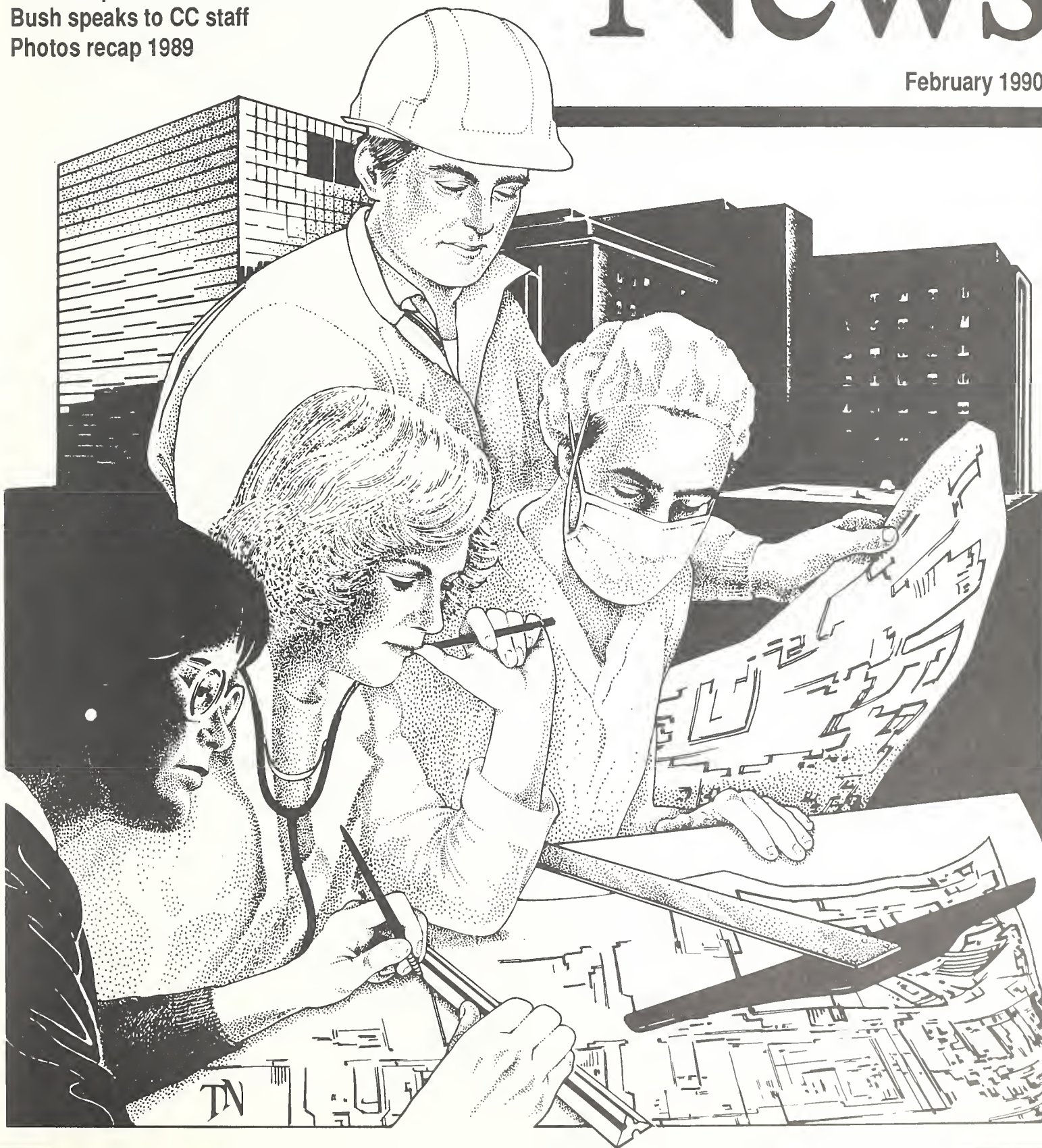


In this issue:

NIH may build new hospital
CC'er helps hurricane victims
Bush speaks to CC staff
Photos recap 1989

Clinical Center News

February 1990



From the editor's desk . . .

We have a special section this month with photographs highlighting 1989. The display includes photographs ranging from annual events such as the Combined Federal Campaign to special events such as President Bush's visit last December. Photos appear on pages 5-6.

Another special feature this month is Social Worker Dale Boggs' first-hand account of Puerto Rico after Hurricane Hugo hit last fall. Boggs was part of the American Red Cross relief program that helped victims of this natural disaster. Her story appears on page 7.

This month's cover story looks at the possibility of building a new hospital, and some alternatives for dealing with building 10's shortcomings. We will keep you informed as new developments unfold.

Don't miss the premier column of *Pharmacy notes*, which appears on page 3. This month's column discusses the inpatient floor stock reordering system. If your department has information to share with other CC employees and you would like to start a column in *CC News*, call me at 496-2563.

Also this month, Dr. Saul Rosen asks health care workers to donate a small amount of their free time to help others; and the health promotion section features setting physical fitness goals for yourself.

Hope you enjoy this issue!

—ejp

Quote of the month

It is completely unimportant. That is why it is so interesting.

Agatha Christie
1891-1976

Letters . . .

Surgery was a success

I recently had surgery and was a patient on 5 East and I feel compelled to write to you about my experience. The nurses in 5 east were absolutely superior. Their dedication, professionalism and compassion deserve more praise than I can offer. Ann, Connie, Joy, Mary, Ralph and Rita made my stay as pleasant as could be.

I must also acknowledge that Hetty and Lynn in neurosurgery were very kind and cooperative. My admissions experience was very pleasant. The people who administered my EKG and x-rays were very friendly and efficient. The personnel at MRI (especially Shirley) were delightful and considerate.

Finally I must commend the talents of Dr. Oldfield, Dr. Luciano, and the rest of the people in the operating room. My quick recovery is a tribute to their excellent work. The people at NIH certainly deserve recognition for the excellent quality of their patient care.

Sincerely,
Norman L. Oremland

A note of thanks

Juan has a diagnosis of Hyper-immunoglobulin E Recurrent Infection (JOB'S) Syndrome. He has been attended

at NIH since 1986 and is now in good condition.

I am his personal physician and, in this medical evaluation, I had the chance to accompany him to NIH. During these two weeks I could see the Clinical Center and I think it's a very important center of medicine. You work hard and very well. Congratulations.

You were friendly. I felt at home. Thank you for everything.

I want to express my gratitude and my acknowledgement to Dr. John Gallin and his team of doctors of the laboratory of clinical investigation, NIAID. Also I am grateful to the nurses of 9 West.

Sincerely yours,
Dr. Osvaldo Azpilicueta
Argentina

Patient coworker expresses thanks

As a patient and also an employee of the Clinical Center, I have witnessed and been a part of many facets of the Clinical Center. I would like to thank everyone who was involved in my care during the past two years. The doctors, nurses and support personnel in the 12th floor clinic and 13 East were superb and always managed to take the time to answer question's and allay fears and apprehensions during some of my very stressful times.

During my recent hospitalization on 13 East for a bone marrow transplant, I encountered many cheerful and optimistic individuals. I would specifically like to thank Leslie Delapeno, my primary nurse; Dr. Larrin Yee, my primary physician; and George Bryant, my protocol nurse, for "being there" at the right times. Their care, encouragement and support demonstrate their dedication to helping others. Keep up the good work.

I would like to heartfully thank all my friends and colleagues who donated leave to me. Thank you for your generous gifts! May all of you have a happy, healthy new year.

Again, I thank all my friends and coworkers, nurses and doctors.

Sincerely,
Patricia Kruczak-Filipov
Clinical Microbiology

Do you have a comment or opinion that you would like to share with other CC employees? Write to us.

Letters, which may be edited for space and clarity, must include the writer's name, work address and telephone number for verification. Names will be withheld upon request and be considered confidential. Send letters to Editor, CC News, building 10, room 1C255.

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CC News articles may be used for publication if appropriate credit is given.

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NIH considers building new hospital 4

Should NIH build a new hospital? Or should it renovate building 10 to meet growing needs? NIH examines the limitations of building 10 and options to remedy the problems.

Remembering 1989 5

And an eventful year it was! We say it all with pictures—ranging from the annual CFC kickoff to a special visit from the President of the United States.

CC social worker helps hurricane victims in Puerto Rico 7

Imagine having the top floor blown off your house. Or, worse yet, have the whole house blow away. Volunteers helped many people readjust after Hurricane Hugo hit last fall.

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Pharmacy notes

From Decker's desk

Fifty hours of giving

Inpatient floor stock reordering system is now computerized. The pharmacy floor stock reordering screens were developed in collaboration with the pharmacy department, inpatient head nurses, the NIS committee and the information systems department. The new screens became operative in MIS in December.

There are two main advantages to computerizing the inpatient floor stock reordering system: speed and accuracy. This would especially be beneficial to inpatient units not served by a transitube or dumbwaiter. No longer will nurses have to locate the pharmacy requisition form and call the messenger service to deliver the form.

Pharmacy personnel are pleased with the system because it minimizes confusion. For example, there are six listings for lidocaine and three listings for heparin, depending on strength or size.

The floor stock screens contain commonly used meds available to all nursing units. They fall into the category of multiple dose containers or refrigerated drugs such as insulins, lidocaine or allergy tests. Other categories are topicals, test supplies or non-prescription meds. Examples include phisohex, BG chemstrips and Fleet enemas.

Orders received before 2 p.m. on weekdays are delivered the same day. "Stat" orders will be filled immediately if followed by a phone call to the unit dose pharmacist at 496-1914.

The screens will be test piloted for six months. Any head nurse who identifies the need to add additional medications to the screens should call Dr. Anthony Brooks, supervisor, unit dose pharmacy, at 496-1914. Technical problems with use of the screens should be referred to Karen Clifford, nurse systems analyst, at 496-9174. Any other concerns should be directed to Mike Boykin at 496-6012 or to your NIS representative. □

Pharmacy notes is written by Anthony Brooks, P.D., pharmacy supervisor. He joined the Clinical Center in 1987.

3 Clinical Center News: February 1990

Those of us involved in patient care at the Clinical Center are no strangers to need. Even in a research hospital, we take care of the sick. We listen to their problems. We carefully examine them for causes of those problems and for others that remain obscure. We probe into their medical histories and the health of their families. We administer to them. We take care of their needs during minor and major procedures. We do all these things, and more, because we are members of a healing profession and proud of it.

Our work is done at some financial sacrifice. None of us has taken the vow of poverty, as Sam Broder has said, but many of us earn considerably less at the Clinical Center than we could earn in the private sector. Yet we do it willingly, content to do our part in helping the patients who literally volunteer to participate in research projects at this great biomedical institution.

Perhaps it is understandable, therefore, that many of us react with mixed emotions when, each year, we are called upon to dig into our pockets for those less fortunate. The Combined Federal Campaign just concluded in our workplace, the countless requests in our mails, and the din of the dunning on our phones, however worthwhile the causes espoused, are rarely greeted with wholehearted enthusiasm.

That being the case, it is either the height of folly or the height ofchutzpah for me to make yet another request—but make it I must. In 1987, the Journal of the American Medical Association, *JAMA*, and the Journal of the American Bar Association, *The Lawyer's Magazine*, published the same editorial. (This must be some kind of first: for doctors and lawyers to reach that level of agreement merits mention in "Magical Moments of Western Civilization.") What George Lundberg, editor of *JAMA*, and Lawrence Bodine, editor of *The Lawyer's Magazine*, asked was for every physician and every lawyer to donate 50 hours each year to the poor.

While I fully endorse this idea, I would go one step further. I would ask not only physicians, but all our healthcare staff—nurses, pharmacists,

technologists, social workers, and others—to make the same commitment.

The numbers given by Lundberg and Bodine are chilling. Up to 50 million Americans are either medically uninsured or seriously underinsured. One can scarcely pick up a newspaper without reading about crises in access to health care.

What Lundberg, Bodine and I recommend is for each professional to donate 50 hours a year—roughly one week of time—to the poor. There are lots of ways healthcare workers can do this. One can volunteer in community hospitals, in free clinics, in the woefully understaffed inner city hospitals, or other care facilities. Whatever your skill, there is a need for it somewhere nearby, and you will be amply rewarded for giving of your time by the good feelings of helping. I have asked Jim Sayers (496-2381), acting chief of the CC social work department, to maintain a list of organizations that would welcome your help.

All of you who read this editorial, and I who wrote it, are among the more fortunate in our society—a society that has given us much. Surely it is not inappropriate for us to give back a bit of what we have gained. The hungry, the homeless, and the medically indigent are simply not being adequately served by our system. Fifty hours a year for the poor is a small contribution, but a step in the right direction nonetheless.

The last paragraph in the AMA-ABA editorials reads: "There is a great tradition behind the giving of this gift. In the church it is called *stewardship*. In law, it is called *pro bono publico*. In medicine, it is called *charity*. In everyday society, it is called *fairness*." Think about it.

—Dr. Saul Rosen

[Editor's note: for potential volunteer work, see page 9]

The administrative column, From Decker's desk, is written by Dr. John Decker, Dr. Saul Rosen, or Mr. Raymond Becich and provides information for or addresses issues of concern to CC employees.

NIH considers building new hospital

By Ellyn J. Pollack

Serious deficiencies in the infrastructure of the Clinical Center have raised the possibility that a new hospital might have to be constructed, according to Juanita Mildenberg, branch chief of FEB, DES.

The infrastructure refers to the utilities within the walls and ceilings, including air conditioning, heat, plumbing, piping, and air ducts. Renovating these utilities will require more square footage than is currently allotted, thereby reducing the already limited space in the Clinical Center.

"The infrastructure of the Clinical Center is overtaxed," says Jim Wilson, building services manager. "We can not get any more out of it. It has been overtaxed for years and it's getting worse."

When the hospital was built in 1949, it was considered state-of-the-art with the latest technology, according to Mr. Wilson. The electrical system was upgraded once and an electrical emergency patient riser, or emergency power, was installed. However, the infrastructure is still too small for today's technology.

Utility requirements for most laboratories and some patient care areas have doubled since the hospital was built 40 years ago, according to Ms. Mildenberg. Personal computers and diagnostic equipment, for example, put a heavier demand on the infrastructure. Utilities are half of what they need to be by today's standards.

"The deficiencies in the CC system have been known to Jim Wilson and others for many years," says Dr. John L. Decker, CC director, "but it is only recently with the continuing growth of activity in the building that the matter has become serious enough for several surveys to be ordered by the division of engineering services (DES)."

Last year, DES hired three contract firms to help assess the condition of the Clinical Center's infrastructure and alternatives for remedying the situation: Cannon Corporation, a professional services firm that specializes in the planning and design of hospitals; Hamilton/KSA, a healthcare consulting firm that emphasizes program/strategic planning and building/facility planning for hospitals; and Earl Walls Associates,



Built in 1949, the hospital was considered state-of-the-art with all of the latest technology.

an architectural and engineering firm that provides programming and design consultation.

According to Ms. Mildenberg, both the hospital and clinic infrastructures have "deficiencies," but those of the clinic are minor compared to those of the hospital.

In renovating the hospital, one-third of the building would have to be done at a time because the infrastructure requires access to an entire section or "tower" of the building, according to John Jenkins, project officer, DES.

"In the building, we have both laboratory and clinical towers," Dr. Decker explains. "If we have to close a clinical tower, we cannot carry on our usual function in the remaining space. The activities of neither the bioscience laboratories nor the ward units can be shut down without unacceptable injury to the research mission of the Clinical Center."

The most likely alternative, Ms. Mildenberg adds, is to build a 500,000-square-foot addition to the Clinical Center. The added space would make it possible to have a tower in building 10 empty while the clinical research continues. The new facility also would provide the extra space needed for the infrastructure. Current floor heights limit the installation of equipment in the ceiling, preventing the hospital from running state-of-the-art laboratories anymore.

"It was not a very long extension to go from the idea of a temporary hospital to be used in that way to the concept of a permanent new building that would leave much space in Building 10 for other pressing needs," Dr. Decker adds.

"If we decide to build another hospital, we would have the new construction first," Mr. Jenkins explains. "We would most likely move patient care and related research into that space. One alternative is to try and make it so that the patient care units and laboratories are only moved once."

"If we are going to gut large areas, what do we want in there—clinical care facilities or research laboratories? We need to decide."

Another alternative, Mr. Jenkins adds, is to cut back existing programs to fit the limited space of the Clinical Center.

The contract firms have finished the second executive summary of the infrastructure and the preliminary options, and are entering the second phase of planning. Dr. Decker, Mr. Wilson, and CC Executive Officer Raymond Becich will review the summary and an executive board will oversee the project.

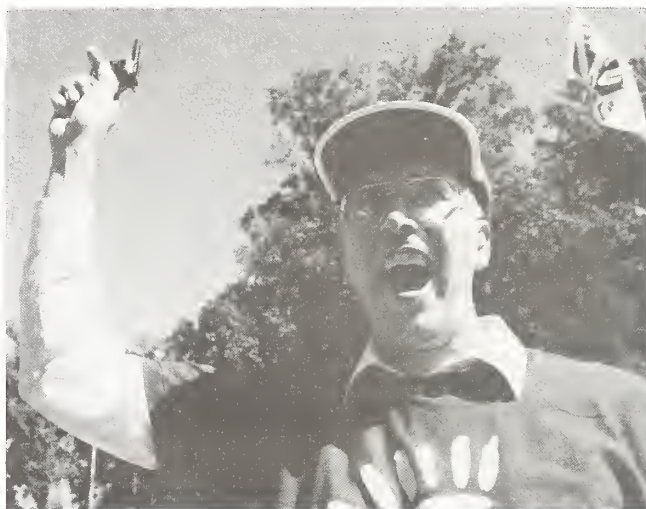
"We are still at a very preliminary stage," Mr. Jenkins says. "In a nutshell, the building is old and the systems are getting unreliable. We have to go to the next step and decide what we want to do about it." The two extremes are to totally replace the Clinical Center or to totally renovate the building. Mr. Jenkins says they are looking for something in between. Regardless of which option is chosen, they currently envision a 10- to 15-year program.

But planning is only half the battle. "Even after the plan is made, we are faced with the necessity of getting money from Congress," Dr. Decker says. The estimated range is \$400-800 million, depending on the final plan proposed. □

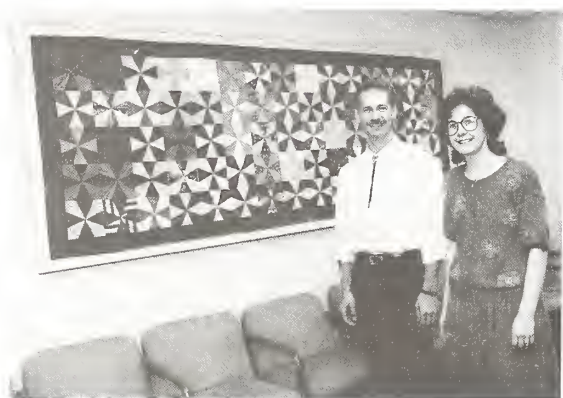
Remembering 1989



PEF Auction



CFC Kickoff



AIDS Quilt



Winterfest



Camp Fantastic



The Children's Inn



Brown Bag Concert



PAD Open House



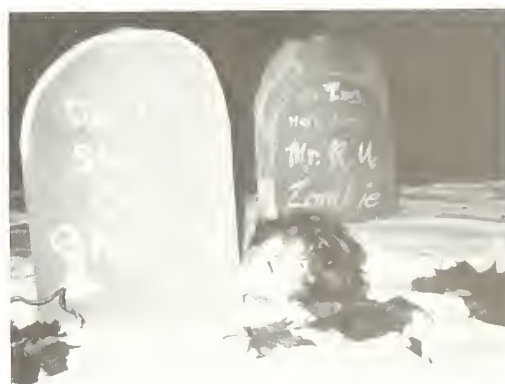
Spiritual Ministry Open House



The President's Visit



Winterfest



Happy Halloween

CC social worker helps hurricane victims in Puerto Rico

By Dale Boggs, MSW, LCSW

The evening of Sept. 21 marked the beginning of my awareness of the magnitude of Hurricane Hugo. I watched anxiously as Hugo swept the Caribbean and aimed at Charleston, S.C.

I had served with the American Red Cross (ARC) on disaster relief operations, and was aware of the devastation caused by such disasters.

Hurricane Hugo became the single most catastrophic natural disaster in the history of ARC. Staffing resources were already stretched to the limit when the October San Francisco earthquake added to the demand. By November, the regular ARC disaster staff and their reserves were exhausted. President Bush then asked government agencies to allow federal employees to help relief agencies when possible.

In November I was appointed by the Clinical Center social work department to represent NIH to the American Red Cross chapter in Montgomery County. I was assigned to the Service of Military Families and Veterans Committee. This assignment placed me in contact with ARC staff who knew of my previous experience with Red Cross. I was asked to work with family services on the disaster relief staff for three weeks in Puerto Rico.

Staff members did not know where or exactly what they might be doing on the operation until they arrived at their destination. Some of my PHS friends had spent a week on St. Croix living in a tent under Viet Nam war-like conditions. Preparations required being ready for any living condition. On Nov. 18 I flew to my assignment in Puerto Rico.

During the trip to a hotel in San Juan, I saw the signs of Hugo's visit everywhere. Palm trees had been spun around and their tops blasted off leaving just a trunk. Sea walls were torn apart and beaches had been rearranged.

After orientation at Disaster Operation Headquarters, I was assigned to work as an itinerant mental health worker. The role of a mental health worker is to help the staff with such stress-related problems as conflicts, personal inability to adapt to meeting the needs of disaster victims, cultural differences and problems generated by being away from home. Crisis-related counseling was available to victims of the disaster as well as staff. The mental health goal was to create a



Hurricane Hugo blew off the top floor of this Puerto Rican house.

link with local mental health resources to provide specific long-term services.

To work in a disaster area, staff had to be flexible, expect the unexpected, and know that self-comfort and personal needs cannot be met until after the work is done. The staff in Puerto Rico worked very long hours in heat and other conditions requiring special health considerations. We had to be careful of food, water and reactions to insect bites.

The operation required continuous staffing of 800 to 900 people; 80 percent were volunteers representing almost every state. Most had worked with ARC or had disaster experience. Firefighters from New York City, nurses from insurance companies, and the Canadian Red Cross were there working together.

There were 18 ARC service centers set up in the Caribbean area in November. The headquarters in Puerto Rico covered St. Croix, St. Thomas, St. John, mainland Puerto Rico and two islands off the coast. Shelters were supported by the Red Cross for the first 30 days of the disaster. ARC served more than 11 million meals.

As a mental health itinerant, I went to the various service centers to consult with staff or provide mental health services. The path of Hugo's eye was most evident on the coast and in mountain areas. There were houses without roofs and others that had been blown apart. Even though it was five weeks after the storm, trees still blocked the roads, and phones and electricity were not working properly. Everywhere I visited it was obvious that both staff and victims had stories they needed to tell. One significant loss was told by a three-year-old girl who had come to the service center located along the most damaged part of the island. She repeated in her native Spanish that she wanted a house. Finally it was determined she had lost her

doll house and wanted another. The staff at the service center took up a collection and bought her a new one.

For the second part of my stay, I went to the Toa Baja service center to help with home visits. To verify loss claims a home visit was essential. There were more than 90,000 cases registered with Family Services. Making home visits meant overcoming such obstacles as the language barrier and the location of homes. Often there were no house numbers or street names. Houses were located behind or on top of each other, or in some isolated location. To reach some homes we rode on horseback or walked miles up a mountain. Guides and interpreters were supplied by the village mayor's office. Once we found our way, we made 15 to 20 home visits a day.

In some ways, Hugo helped people receive assistance who otherwise might not have. On one of my visits, a 26-year-old woman who had cerebral palsy with probable mental retardation was confined to bed. Her room and hospital bed had been damaged by the hurricane. Through the Rotary Club, we were able to get her a wheelchair so her 74-year-old grandmother could take her outside.

Some people did not want help. A guide showed us families who would not go to a shelter. They used old World War II Navy bunkers that were dug into the hillsides.

The Puerto Rican people were very appreciative of the disaster relief given by ARC and the federal government. I felt well rewarded for my efforts, and Hurricane Hugo is one experience I'll never forget. □

Dale Boggs, MSW, LCSW, joined the CC social work department in 1976. She works with the medicine branch, NCI. She also worked for NINDS for ten years.



While visiting AIDS patients and their families, President Bush took time out to thank NIH health care workers who provide care to AIDS patients.



More than 100 employees and guests gathered at the Bethesda Naval Commissioned Officer's Club for the first annual "Winterfest Twelfth Night Celebration." Throughout the evening, the dance floor remained packed. Between dances, guests strolled down the cocktail buffet, which offered selections of barbecued meatballs, marinated chicken drumettes, hot breaded shrimp with cocktail sauce, and hot crab balls. As winner of the door prize, Dr. Andrew Dwyer, medical officer in diagnostic radiology, won dinner with Dr. and Mrs. John Decker.

Code Blue policy

If you are in the Clinical Center, you should "call a code" whenever you or someone in the immediate area has a significant medical problem that needs expert medical assistance as soon as possible.

You should not "call a code" just to get a wheelchair (call the admissions desk at 496-3315) or have a patient taken to the occupational medical service (call the fire department at 116 and ask for transport of a patient) or to have an ambulance take a

non-emergency patient to another hospital (call the fire department at 116). These situations can be handled by a telephone call, as noted above.

Do not call 911—that confuses the 911 operators who will call the NIH operators and activate an unnecessary "code blue."

If you have questions about the appropriate action before an emergency occurs, call Dr. Harry Keiser at 496-1518. □

News briefs . . .

The 1989 Combined Federal Campaign collected \$76,000. Overall, 47 percent of NIH employees participated in the campaign, including 63 percent of all full-time employees.

The clinical pathology department raised more than \$1,583 in its annual Patient Emergency Fund (PEF) auction. More than \$800 of the proceeds will go to the PEF; the Children's Inn will receive \$765. What began as a small auction initiated by the clinical chemistry and microbiology services 16 years ago has grown over the years to encompass the entire clinical pathology department. A wide variety of homemade food, crafts, plants and "white elephant" items were auctioned off to an enthusiastic crowd of bidders. Postal Pizza donated 10 large pizzas, which were bought by spectators and participants. Dianne Cohan was the auctioneer for the 16th year.

An automatic sprinkler system will be installed in December 1990 throughout building 10. The division of engineering services will discuss the installation 9-11 a.m. on Tues., Feb. 20, in the Lipsett Amphitheater. Due to the sensitivity, importance and impact of this program on building operations, all occupants of building 10 are encouraged to attend. □

NIA seeks volunteers

The Laboratory of Neurosciences, NIA, seeks participants for two separate studies.

Healthy volunteers are needed to participate in a study investigating the effects of aging on brain functions. Researchers need men between the ages of 18 and 30 and men over 60. Participants must be drug-free during the study and free of all major medical problems, past and present. Each participant may receive a stipend of up to \$300, depending on the actual time involved.

For a separate study on depression in adults, researchers are seeking volunteers who are 45 years or older and suffering from depression. The study does not involve drug treatment.

For more information on either study, call 496-4754 9 a.m. to 5 p.m. Monday through Friday. □

CC newsmakers

Jerry King, chief of the medical record department, received the "Director's Award" for 1989 in recognition of his successful patient confidentiality campaign.

Two people recently retired from the CC hematology service. **Teri Smith**, senior technologist, worked for the CC hematology service for 27 years. **Joan Ruberg**, medical technician, retired after working for 33 years in the hematology service.

The clinical pathology black culture committee recently held its fourth annual

luncheon honoring Black History Month. More than \$800 was raised through luncheon ticket sales, with all proceeds going to the United Negro College Fund.

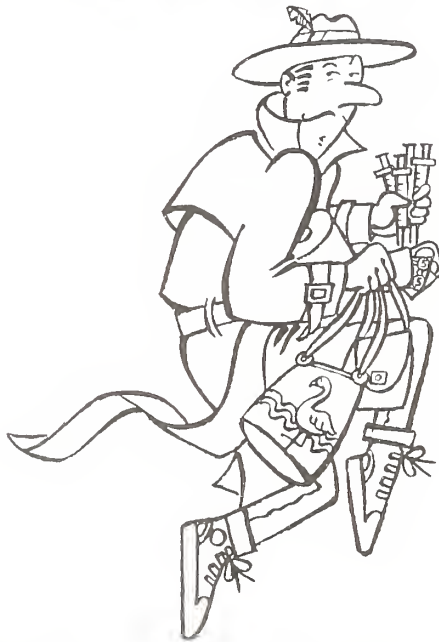
Thirteen phlebotomists donated three to four hours of their time drawing blood in search of a bone marrow donor for a young college student who has leukemia. Volunteering their time were: **Cynthia Crews**, **Keith Lee**, **Shellah Sullivan**, **Steven Yen**, **Sonia Macewicz**, **Phyllis Kuyateh**, **Elleen Welkert**, **Veronica Washington**, **Mattie Robinson**, **Edith Powell**, **Norma Silva**, **Johnny Davis**, and **Joyce Watson**.

CC gallery artists

February 13-April 10

Gallery I	Doris Foss watercolors
Gallery II	Judith Briggs pastels
Gallery III	Marie Skora multi-media
Gallery V	Dick Higgins watercolors
Gallery 31	Mary Teichman prints
Sculpture I	Joyce Nice ceramics
Sculpture II	Nigel Briggs wood bowls

Looks aren't everything.



But if you see someone who looks interested
in stealing your property, call Security.
Stop crime before it happens.
Dial 115 to report suspicious activity in your area.

**CRIME
WATCH**

Clinic needs caregivers

The Whitman-Walker Clinic is a community-based organization that provides medical and social services to people living with AIDS and others who are HIV positive. The clinic relies on the generous support of volunteers who fill more than 30 volunteer positions. The clinic currently has a critical shortage of nurses, doctors and physician assistants. A couple of hours of volunteer work every week or month will assist greatly in serving a growing list of clients. Training and supervision is provided. To volunteer, call the Whitman-Walker Clinic at 797-3576. □

NIMH seeks volunteers

The NIMH section of anxiety and affective disorders seeks individuals with panic disorder, agoraphobia or social phobia to participate in research investigating the causes and treatment of these disorders. Participants will receive free comprehensive diagnostic assessments and treatment by physicians specializing in anxiety disorders. Currently participants with other major medical illnesses will not be accepted. For more information, call Barbara Scupi, LCSW, at 496-7141. □

A vision of fitness

Goal-setting for health achievement

The most important part of developing a personal plan for physical fitness is knowing why you want to become more fit. As simple as that may sound, it is actually a critical aspect of a successful fitness plan. If your goal is weight loss, you'll approach fitness somewhat differently than if your goal is building strength and endurance. And, once you know why you want to become more fit, you can more easily determine what you can do to reach that goal.

It is also a good idea for people with any significant past medical history of illness to see their doctor or another qualified health practitioner before beginning any physical activity.

Set long-range goals

Be specific. Sit down with a paper and pencil and jot down exactly what you hope to accomplish by becoming more physically fit. Do you want to lose weight? If so, how much? Do you want to improve your endurance? If so, why? If

you wish to improve specific skills (your bicycling, swimming, or golf game, for instance) state them. Knowing what you want in the long-run will help you tailor your program to achieve your ends as well as motivate you to follow through with your "working" goals.

Set working goals

If your long-range goal is to lose 15 pounds, start by setting short-range "working" goals—small steps that will help you reach your long-range wish. "Working" goals say what, how much, and how often you will do an activity to help you move toward your final goal. For instance, a working goal might be to attend a one-hour exercise class after work on Monday, Wednesday, and Friday. Each time you attend a class, you've met one working goal. If your ultimate goal is to increase the weight you can bench-press, your working goals will center around progressively "overloading" your muscles to help build strength.

Keep a planner

The best way to outline working goals—and to make your fitness plan a firm commitment—is to keep a planner. Write down the activities you will do, which days you will do them, and when and how long you will do them. It's best to space your workouts at least one day apart to allow for adequate recovery time, so if you exercise vigorously on Monday, wait until Wednesday to repeat that activity. (Remember, for optimum results, you should exercise vigorously three to five times a week.) When you've accomplished each goal, take a minute to write a comment or two on how you felt afterward. Did you feel a sense of accomplishment? Have you noticed that you're exercising with greater ease than when you first started? Did eating lunch before your workout affect your performance? Keep notes about your progress and use this information to analyze any problems you may be having as well as to award your achievement.

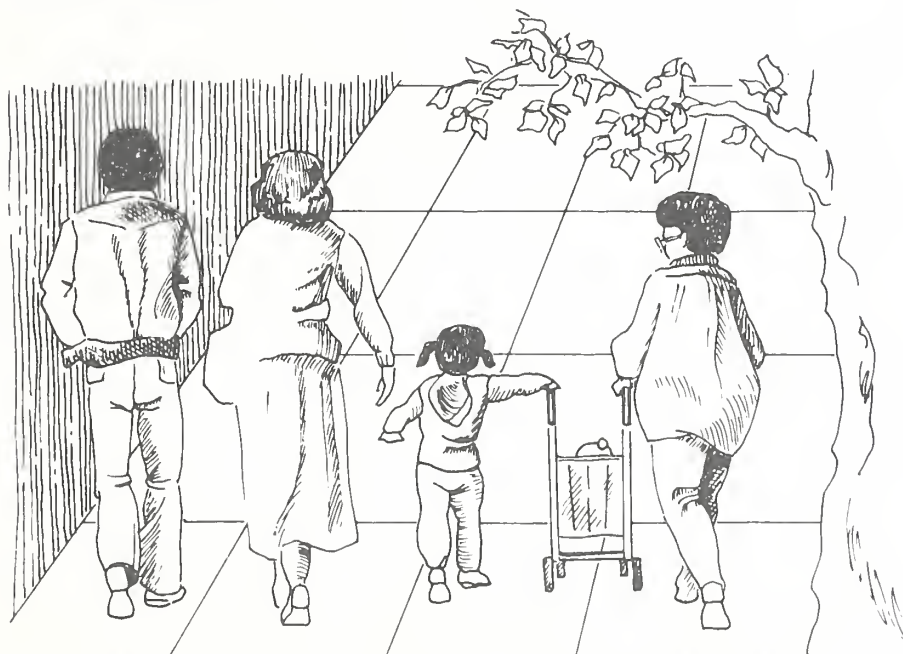
The payoff

Long-range goals—the payoff—can be easy to lose sight of; that's why working goals and planners are important. By writing down what you hope to accomplish and setting well-planned working goals, you'll find that the payoff isn't the impossible dream, it's the final success in a series of hard-earned achievements.

In fact, a recent article in the *Journal of the American Medical Association* states that "Moderate levels of physical fitness that are attainable by most adults appear to be protective against early mortality." The article suggested that just a brisk walk of 30 to 60 minutes each day would benefit most men and women. □

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** from the article "Physical Fitness and All-Cause Mortality: A Prospective Study of Healthy Men and Women." by Steven N. Blair, et al, JAMA 1989; 262:2395-2401.*

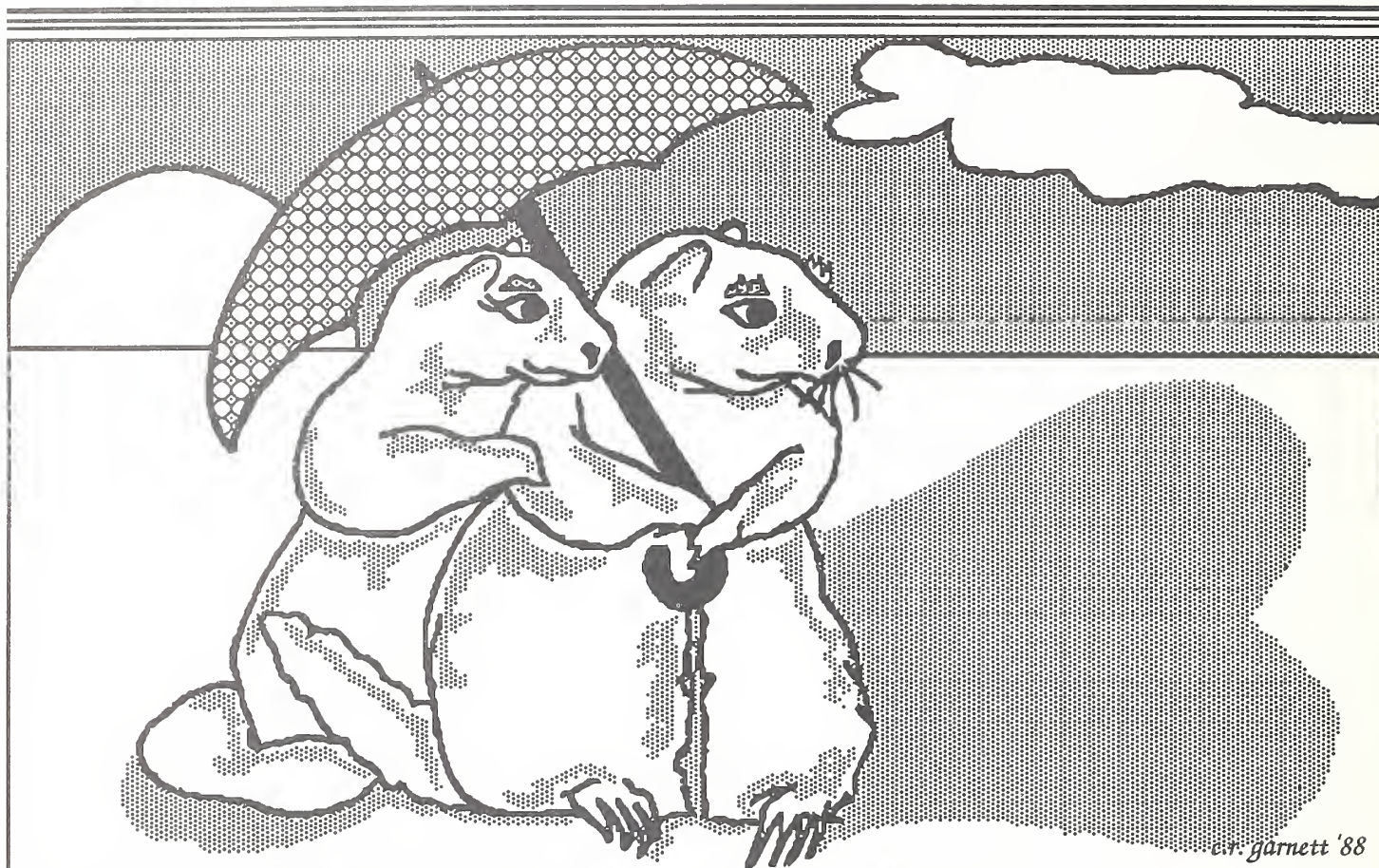


Your whole family can benefit from the joys of movement. Make fitness your family legacy.

This health promotion information was developed by the Office of Clinical Center Communications in cooperation with the Occupational Medical Service (NIH Division of Safety) and the Clinical Center Department of Rehabilitation Medicine. For administrative use only.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service • National Institutes of Health

Clinical Center News: February 1990 10



FEBRUARY CALENDAR OF EVENTS

1 Lecture. *The Gardens of Pompeii and the Area Destroyed by Vesuvius*. Dr. Wilhelmina Jashemski, University of Maryland. Sponsored by the Order Sons of Italy in America (OSIA) Lodge. Lipsett Amphitheater, noon.

7 Grand Rounds. *Molecular Motors: From Hay Fever to Heart Disease*. Dr. Robert Adelstein, NHLBI. Clinical Center Alum Presentation—*Cystic Fibrosis: Research Advances and New Clinical Perspectives*. Dr. Thomas Boat, University of North Carolina School of Medicine. Lipsett Amphitheater, noon-1 p.m.

13 Christian Anfinsen Neuroscience Seminar. For more information, call 496-9106. Masur Auditorium, 5-6:30 p.m.

14 Grand Rounds. *PET Scanning and Epilepsy*. Dr. William Theodore, NINDS. *Malignant Lymphomas: Master Mimics of the Immune System*. Dr. Elaine Jaffe, NCI. Lipsett Amphitheater, noon-1 p.m.

14 R.E. Dyer Lecture. *Retroviruses: Where Did They Come From, and Where Are They Going?* Dr. Malcolm A. Martin, NIAID. Masur Auditorium, 3 p.m.

15 Medical Scientists Committee Lecture. For more information, call Genevieve Schiffmann at 496-1156. Masur Auditorium, noon-1 p.m.

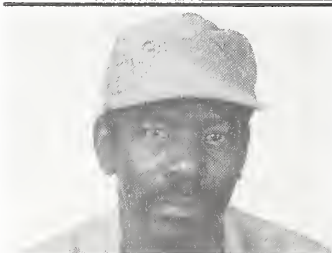
16 Black History Awareness Program. For more information, call Irene Peyton at 496-6301. Masur Auditorium, 11:30 a.m. to 1 p.m.

20 DES Presentation regarding the installation of an automatic sprinkler system in building 10. Lipsett Amphitheater, 9-11 a.m.

21 Grand Rounds. *Biologic Factors in Disruptive Behavior*. Dr. Markus Kruesi, NIMH. *Parathormone-like Peptide: A Novel Factor Causing the Cancer Hypercalcemia Syndrome*. Dr. Allen Spiegel, NIDDK. Lipsett Amphitheater, noon-1 p.m.

28 Clinical Staff Conference. *Gastrointestinal Infections in the Acquired Immunodeficiency Syndrome*. Dr. Phillip Smith, NIDR, moderator. Lipsett Amphitheater, noon-1:30 p.m.

28 Meeting of the Greater Washington Area Coalition for Cancer Survivorship. Lipsett Amphitheater, 7-10 p.m.



CC News is published monthly for employees like John Smith, temporary group leader for housekeeping and fabric care department. He has worked in the Clinical Center for one year. He enjoys meeting people from different countries who visit the CC, and the interesting people who work in building 10. "All in all, I feel the Clinical Center is a great place to work with a lot of friendly people," he adds.